Mind, Brain, and the Problem of Responsibility

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The word "mind" names one of our most important, but most confused and confusing, ideas. As a verb, "to mind" implies agency, intention, and responsibility, *qualities* that we attribute only to intelligent, sentient beings. Attributing, or refusing to attribute, moral agency to the Other is both a matter of description or fact and a matter of prescription or tactic, that is, a decision that depends not only on the Other's abilities, but also on our attitude toward him.

Although the "mind" is not a biological entity or scientific concept, "it" is now regularly studied by biologists, neurophilosophers, neuroscientists, and psychiatrists, many of whom ignore the actual uses of the term and, instead, treat the mind as if it were the brain, or a function of the brain, or as if the words "mind" and "brain" were synonyms. To anyone who speaks English fluently, this claim must seem extremely odd. Nevertheless, there is no shortage of prominent persons who make precisely that claim. "The mind is the brain," states Daniel C. Dennett, professor of philosophy at Tufts University. "Brain and mind are one," writes Alan J. Hobson, professor of psychiatry at Harvard University. In his book, *The Rediscovery of the Mind*, John R. Searle, professor of philosophy at the University of California at Berkeley, coins a new English compound noun, "mind/brain," attributes "biologically basic intrinsic intentionality" to it, and claims that "meaning" is "grounded in" it. This cannot be right. Meaning is grounded in culture, memory, and language, not in an imaginary mind/brain.

In order to evaluate properly the merits of studies based on such claims and premises, we must not lose sight of the fact that the word "mind" is a part of our everyday vocabulary and that we use it most often, with the most far-reaching practical consequences, in psychiatry, law, and ordinary discourse.

In a much-neglected little book, titled *Autistic and Undisciplined Thinking in Medicine and How to Overcome It*, originally published in 1919, Eugen Bleuler sounded this cautionary note: "When the doctor wishes to give the patient a modicum of encouragement, he tells him that his state of nerves is due to overwork; when he wishes to give himself a boost and puff up his ego at the patient's expense, he tells him that his nervous condition is due to masturbation; both statements are autistic ... autistic thinking is paranoid and leads to hallucination." Bleuler also complained, much as he did in his classic work on schizophrenia, that the definitions of mental illness "modern legislation compels us [to construct] are forensic and not medical." In *Dementia Praecox or the Group of Schizophrenias*, he had written: "People are being *forced* to continue to live a life that has become unbearable for them for *valid reasons*.... Even if a few more [patients] killed themselves, does this reason justify the fact that we *torture* hundreds of patients and *aggravate* their disease?" Who was—and still is—forcing suicidal persons to live? Psychiatrists.

In his textbook of psychopathology, first published in 1913, Karl Jaspers emphasized the differences between hospitalized medical patients and hospitalized mental patients in terms that leave no room for misunderstanding. He wrote: "Admission

to hospital often takes place against the will of the patient and therefore the psychiatrist finds himself in a different relation to his patient than other doctors. He tries to make this difference as negligible as possible by deliberately emphasizing his purely medical approach to the patient, but the latter in many cases is quite convinced that he is well and resists these medical efforts." However, Jaspers did not oppose involuntary psychiatric interventions. On the contrary, in conformity with psychiatric convention, he noted that "Outside hospital we must consider particularly the *danger of suicide* and the *extent to which the patient is dangerous to others*."

When Bleuler acknowledged that definitions of mental illness are "not medical," he understated the case. Definitions of mental illness are prescriptive, not descriptive. This fact has profound implications for our views on the connections between brain and mind and the actual or alleged diseases attributed to them.

Before considering those connections, a few remarks about our use of the terms "brain" and "mind" are in order. The meaning of the word "brain" (in English and other Western languages) and the object it names are clear and uncontroversial. The same cannot be said about the meaning of the word "mind." Until the seventeenth century, the word "mind" was used only as a verb: "to mind" meant to heed, which implied agency, intention, and will. Once " mind" became a noun, it was expected to refer to an object. Was that object a *thing*, like the brain, or an *abstraction*, like the soul? Anatomists and neurosurgeons never mistake the brain for the mind and never call it "mind." Why are most contemporary philosophers and psychiatrists so eager to treat the terms as synonyms?

Pragmatically, we infer the meaning of words from their uses. Clearly, when we talk about an individual's mind, we are talking about him as a person, but when we talk about a person's brain (or other organs), we are not. Specifically, we use the word "mind" in lieu of the word "person" when we attribute legal or psychiatric non-responsibility or incompetence to him.

Organs, like the heart or the liver, can be defined by their functions, persons cannot. We rightly regard assigning a specific function to men or women and defining them by that function as the worst kind of political dehumanization. Disobedience is no less human nor less biologically "normal" than obedience. If we were to identify persons by a distinguishing function, that function would be existential-moral, not biological-medical; it would be the capacity and the duty to *make choices and assume responsibility for them,* a function we often attribute to the *mind.* These observations support the suggestion of George Herbert Mead that, if we wish to understand the mind, we must look to its connections with the self and society, rather than to its connections with the brain.

Actually, when we use the word "mind" in law or psychiatry, it stands for a reified-hypothesized "organ" that we treat as if it were the seat of *responsibility*. Let us not forget, or deny, that psychiatry is far more closely related to law than to medicine. In every advanced society, psychiatrists regularly make legally consequential pronouncements regarding the "competence" and "criminal responsibility" of individuals, resulting, respectively, in their being deprived of liberty or excused of crimes. These legal-psychiatric acts are older and more permanent in their character than the seemingly medical acts of diagnosing and treating mental disorders.

The mind is dependent on language, as respiration is dependent on the lung. Minding, like breathing, is an activity, a doing. Doing what? *Talking to oneself.* Speech, the basic form of language, is oral and aural. Language as visual action—as writing and reading—is a later, far more complex, cultural and personal achievement. The linguistic building block we use to construct the mind is self-conversation (*Selbstgespraech*). Self-conversation is the ability to have a conversation with oneself, the self acting both as speaker and listener, the "I" and the "me" speaking and listening, as one to another. When we talk to ourselves while asleep, we are dreaming. (Because inner speech is disinhibited during sleep, in our dreams we "say" and "see" things involuntarily.) When we talk to ourselves while awake—in ways permitted in our society—we are thinking or praying. And when we talk to ourselves while awake—in ways prohibited in our society—we are (said to be hallucinating and hence) crazy.

It seems to me self-evident that if a person is hallucinating—that is, if he claims to be "hearing voices" when no one is speaking to him—he is "hearing" his own inner voice. Who else's could he be hearing? In 1993, neurologists using neuroimaging studies showed conclusively that in the brain of the hallucinating person, Broca's area, controlling speech, not Wernicke's, controlling hearing, is activated.

People intuitively recognize that thinking is self-conversation and that speaking and listening to oneself are ordinary, normal acts. Children talk to their dolls and must learn to talk to themselves inaudibly. When cultural critic Harold Bloom tells a reporter that "The utility of literature is to teach us not how to talk to others, but how to talk to ourselves" (*Newsweek*, October 10, 1994, p. 62), we have no difficulty understanding what Bloom means. However, our cultural conventions limit our acceptance and understanding of self-conversation to certain contexts, especially humor, literature, and religion. "I like to talk to myself," quips comedian Jackie Mason, "because I like to deal with a better class of people."

The contemporary cultural rejection of the ordinariness of self-conversation and its psychiatric categorization as "hallucination" is reminiscent of the earlier cultural rejection of the ordinariness of erotic self-stimulation and its psychiatric categorization as "self-abuse" leading to "masturbatory insanity." We believe that hallucination is a manifestation of a severe mental/brain disease. For more than two hundred years—until mid-century—people believed that masturbation caused severe mental / brain disease. How convenient it is to forget!

To be accepted as sane (normal), the individual must acknowledge his self-conversation as his own (thinking) and must learn to talk to himself silently, in private. Talking to oneself audibly, in public (for example, as do "schizophrenics"), is better explained by attributing it to a dearth of sympathetic listeners or a preference for one's own company, than to brain dysfunction, albeit it may be present as well (for example, in senile persons who talk to themselves aloud).

What distinguishes hallucination or crazy self-conversation from its normal variant is what psychiatrists call "projection." I call it rejection of responsibility for *one's own thoughts, for one's own identity, for who one is*. The person said to be hallucinating disavows his thoughts and attributes them to "voices" originating outside of himself. We may say that a telephone directory is "telling" us that the number for Hotel X is such and such, but we do not claim that we receive that information through our ears, much less that we don't want to hear it. In contrast, prophets and some so-called psychotic persons claim that God is speaking to them or that they "hear voices" and insist that the messages are wholly external to them. If such a self-conversationalist attributes his voice to God, and if the authorities and people accept his claim as true, then they hail him as a prophet. If, however, he makes the same attribution and the authorities and people reject his claim as false, then they declare him to be a false messiah and ostracize him, if he lives in a religious culture, or, if he lives in a "rationalist" culture, they declare him to be mad and lock him up in an insane asylum. As I wrote some time ago: "If you talk to God, you are praying; if God talks to you, you have schizophrenia." In short, prayer is autologue *validated by religion,* whereas hallucination is autologue *invalidated by psychiatry*. A hallucinated perception implies a realistic perception from which it deviates. There can be no "hallucination" without "reality," and no "reality" without a (properly functioning) "mind."

Hallucinating, that is, talking to oneself—as though talking to another person—is a voluntary act. This does not mean that deciding to have one thought rather than another is like deciding whether to wear one tie or another. Nor does it mean that we cannot have unwanted thoughts, that is, inner voices—like Lady Macbeth's—reminding us of what we should not have done.

Like much of our behavior, our self-conversation or thinking is on automatic pilot. In that metaphorical sense, we may call it "unwilled." When an artist or scientist has a seemingly unintended (good) idea, we say he is "inspired" and call him a "genius." When an unhappy, unemployed person has an unintended (bad) thought, we say he "hears voices" and call him "mentally ill" (and attribute his "hallucination" to brain disease). To me at least, it seems very unlikely that the brain can distinguish between two acts that are similar in all important respects except with respect to the *value* we attach to each.

The paradigmatic act of self-conversation is our conscience, the inner judge that holds us responsible for what we do. The word "responsible" comes from the Latin *respondere*, which means to respond, hence its synonym, "answerable." Although we often say that a person "has" responsibility, that locution is misleading. A physician can examine a person's body to determine whether his kidney function is diminished or absent, because of renal disease; but he cannot examine a person's mind to determine whether "its" responsibility is diminished or annulled, because of mental disease—although that is precisely what the psychia-

trist claims to be able to do and society accepts that he is able to do.

The language we use to speak about behavior largely determines our position on the issue of responsibility. The discourse of minding implies responsibility. The discourse of brain function does not. The law recognizes disease of the mind, but not disease of the brain, as a ground for civil commitment or as an excuse for crime. The proposition that "brain is mind" is not a fact or even a scientific hypothesis, as its supporters claim; instead, it is a rhetorical ruse concealing our unceasing struggle to control persons by controlling the vocabulary.

In short, insanity is not simply a property of the Other or his brain; rather, it is an attribution the self creates for the Other, to protect himself from having to hold the Other responsible for certain misdeeds and to justify treating the Other with coercive paternalism, as if he were an infant or pet.

Not surprisingly, modern society's experts make frequent use of two tactics exploiting the conceptual dependence of moral agency on mindedness. One is attributing incompetence to the Other albeit he is, in fact, competent and wants to be so treated; the result is that we harm him under the guise of helping him. The other is treating the Other as a victim when, in fact, he is an agent, a victimizer of himself or others; the result is that we excuse him of responsibility for his self-victimization or the victimization of others.

Because the term "mind" is so richly evocative of what we mean by a person's self and his responsibility for his actions, it is impossible to speak or write about the connections between brain and mind in a moral vacuum—that is, without considering the impact of our views on psychiatry as one of modern society's most important instruments of social control. Although we may prefer to look the other way, the psychiatrist's two paradigmatic professional activities—depriving innocent persons of liberty (called "civil commitment"), and excusing guilty persons of crime (called the "insanity defense")—will not go away. As long as these practices prevail, the most common and most important uses of the term "mind" are its uses in psychiatry. And as long as that remains the case, we must acknowledge that our analysis of the brain-mind relationship will validate or invalidate, support or oppose the legitimacy and "rationality" of psychiatric coercions and excuses. *Tertium non datur.*

SUGGESTED FURTHER READINGS

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